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Commentary on Roosmaryn Pilgram's "Pragma-Dialectical Analysis of Medical Consultation"

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1. INTRODUCTION

Roosmaryn Pilgram establishes the medical consultation as a communicative activity type in which argumentation has the potential to play an important role. According to Pilgram, argumentative discourse becomes a feature of the medical consultation when there is an attempt by a doctor and patient to resolve the lack of agreement or doubt regarding the doctor's medical advice. Consequently, she argues that pragma-dialectic theory provides a suitable framework for the analysis and evaluation of negotiation in the medical consultation. Pilgram specifies preconditions for strategic manoeuvring by the doctor and patient that is designed to regulate the disagreement in medical consultation. She illustrates, with an example from a paediatric consultation, how the conventions of medical consultation affect argumentative discourse.

2. VALUABLE ELEMENTS

Pilgram's work is to be commended for its approach to analysing and interpreting medical discourse. Clinical communication specialists are calling for new parameters of communication that might draw on inter-disciplinary knowledge and experience to inform how communication is conceptualised (Skelton, 2008, p. 154). There has been a tendency among health care professionals to regard clinical communication simply as a set of concrete and observable *skills* selected to achieve a strategy (Brown & Bylund 2008, p. 39; Skelton 2008). Pilgram's emphasis on the role of argumentation in medical communication moves beyond mere description of skills to support a focus on goal orientation in communication *strategy*, an approach that is very much needed in medical communication research, training and practice.

Communicative *competence* is distinguished from communicative *performance*, both in the linguistic and medical communication literature (Hymes 1972; Skelton 2008, p. 74). Pilgram references the work of Dell Hymes, which has been significant in developing the notion that socially and institutionally constructed norms or rules of communicative behaviour are part of one's cultural—and by extension, professional—knowledge (Hymes 1972; 1974). Pilgram significantly promotes a functional emphasis

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that relates the speech event or communicative activity to the goal of discourse, which is accommodated in the pragma-dialectical approach. I believe that this is a significant strength of Pilgram's work because research in this vein encourages communication researchers to consider more closely the alignment of language, communication and culture with desired outcomes of clinical practice. This supports a strategy for integrating communication more closely with the development of professional competency and emphasises the communicative process not merely the communicative product (*cf.* Gilbert, Bird & Jolly forthcoming; Gilbert, Barton & Wenzel forthcoming). Discourse analysis is a recent innovation in the medical education field as knowledge of the conventions of discourse in medical contexts for guiding interaction towards professional goals is assuming greater status (Cameron & Williams 1997; Gilbert 2009). Therefore, Pilgram's work supports the recent call (e.g. Skelton, 2008) for a new orientation in clinical communication research.

3. CONTROVERSIAL ELEMENTS

While Pilgram's work is a welcome emphasis on discourse strategy in medical communication, and this kind of work is likely to receive interest in the medical education/research fields where discourse analysis is assuming greater status, some aspects of her paper require attention.

First, in the research and teaching of doctor-patient communication, although Pilgram acknowledges the shift since the 1970s towards a 'patient-centred' approach, her concept of the medical consultation or interview assumes for the most part a traditional clinical method of data gathering and problem orientation (*cf.* Kurtz, Silverman *et al.* 2003). While the *complaint presentation, verbal and physical examination, diagnosis, treatment, prescription* and/or *advice* components are important elements of the medical interview, clinical communication skills educationalists and theorists have developed models of the patient-centred interview that foster more egalitarian relationships between doctor and patient and so integrate the patient's as well as the doctor's agenda (Brown 2008).

Pilgram might consider the communication frameworks that exist in recent medical education literature to help inform her interpretation of the organisation and purpose of discourse in the medical consultation. She might thence consider the implications of a more complex communication model for the identification and analysis of strategic manoeuvring; for example, considering how communication (or argument) strategy responds to the perspectives, feelings and intentions of others (*cf.* Brown & Bylund 2008, p. 38). Helpful works include: Jo Brown's account of 20 years of key political, sociological, historical and policy influences on clinical communication development (Brown 2008); Richard Brown & Carma Bylund's work that distinguishes between position-centred and person-centred approaches in communication orientation (Brown & Bylund 2008), Ian McWhinney's model that integrates the disease framework of the doctor's agenda with the illness framework of the patient's agenda (McWhinney 1989) and the modified Calgary-Cambridge guides to the medical interview in which Suzanne Kurtz, Jonathan Silverman and colleagues endeavour to marry the two apparently conflicting models of the clinical interview, content and process (Kurtz, Silverman *et al.* 2003).

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Similarly, diagnosis and prognosis are not necessarily characteristic elements of the medical consultation, as Pilgram claims (p. 4). The medical consultation can show a range of functions; for example: in addition to diagnostic assessment there may be risk assessment, routine follow-up, therapeutic decision-making, and counselling. Furthermore, the medical consultation is really an iterative process and so communicative goals and interlocutor agendas may not be realised in a single consultation¹. Pilgram recognises the “limited time of the consultation” (p. 1). She also cites an example of discourse from a follow-up rather than an initial consultation with the parents of a toddler. Pilgram might therefore consider how the pragma-dialectical approach can accommodate an iterative process of negotiation conducted over possibly one, two or more consultations. Bringing together the analyses of a series of related consultations might offer valuable perspectives on the negotiation process and help convey the authenticity of negotiation in daily clinical practice.

Pilgram’s work supports the integration of argumentation in medical discourse frameworks. She posits situations in which the doctor may provide arguments either to justify their opinions on diagnosis and/or management, to dispel professional liability, and encourage compliance (p. 4). Yet, one point of concern in the application of a pragma-dialectical approach is the assumption at the outset of a ‘conflict of interest’ between the doctor (protagonist) and the patient (antagonist), which counters the notion of partnership in shared decision-making at the intersection of their supposedly common interest in the patient’s health and well-being (*cf.* Brown 2008)². The confrontational context and the antagonist-protagonist relationship, along with Pilgram’s deference to the doctor as the more influential “discussion leader” (p. 7), imposes a potentially authoritarian relationship between the doctor and patient, consistent with Pilgram’s use of a traditional clinical method in specifying the framework of the medical consultation. While the real world of clinical practice may sometimes see doctors assume authoritarian positions in their negotiations with patients, one must distinguish between a doctor’s intention to reach a point of compliance (acquiescence to a command or wish) versus concordance (agreement in a process of shared decision-making). Therefore, while pragma-dialectic theory provides a framework for analysing negotiation designed to resolve a difference of opinion, one must not necessarily assume an initial starting point of a conflict of interest when analysing the medical consultation. Both patient and doctor may proffer as a starting point for the consultation different opinions that do not necessarily represent a conflict of interest but rather are presented by the interlocutors in mutual recognition of an agenda to use arguments in a dialogic interaction for exploring plausible options for negotiating agreements (*cf.* the process of inquiry, Blair 2004).

Pilgram provides in Example 1 a discourse sample of authentic medical consultation to illustrate how the socially and institutionally constructed norms of the consultation encounter exert influence on the argumentative discourse generated in the setting. Pilgram’s interpretation of the discourse reveals the communicative process that supports the strategic manoeuvring of the interlocutors and is useful for helping the reader to understand the principles of analysis. More examples across a greater range and

¹ This concept is incorporated in the model of reasoning presented in the paper to be presented at the OSSA conference by Gilbert & Whyte on ‘Argument and Medicine: A Model of Reasoning for Clinical Practice’

² This point was also raised by my colleague, Andrea Paul, when we discussed principles of pragma-dialectical approaches to the medical consultation

sequence of medical consultations (as outlined above) might convince the reader of a more generally relevant application of the pragma-dialectical approach in the analysis of argumentative discourse in the medical consultation and see it accommodating negotiation not limited to resolving a difference of opinion but aimed at establishing concordance in clinical practice.

4. CONCLUSION

Pilgram supports the role of argumentation in medical discourse and shows the relevance of a pragma-dialectical approach in the analysis and evaluation of negotiation in the medical consultation. Her work offers a new orientation in clinical communication research at a time when the medical education field is calling for interdisciplinary knowledge and experience to inform how communication is conceptualised. Pilgram's work would benefit from accommodating insights on patient-centred communication frameworks and notions of concordance in negotiation in the medical literature. The application of the pragma-dialectical approach to the analysis of discourse in medical consultation may face challenges from medical experts not necessarily convinced that a disagreement or conflict of interest typically marks the commencement of the medical consultation.

[Link to Paper](#)

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